ARIZONA HEALTH CARE COST CONTAINMENT SYSTEM (AHCCCS)

Companion Document and Transaction Specifications for HIPAA 837 Encounter Transactions

Version 2.0
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Revision History

Date	Version	Description	Author
10/28/03	1.0	Initial draft	AHCCCS Information Services Division
12/19/03	2.0	Draft Companion Document for 837 Encounters implementation	AHCCCS Information Services Division

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Table of Contents

1 Introduction

1.1 Document Purpose

Companion Documents

HIPAA Transaction Companion Documents are available to electronic trading partners (health plans, program contractors, providers, third party processors, and billing services) to clarify information on HIPAA-compliant electronic interfaces with AHCCCS. The following Companion Documents are being produced:

- 834 Enrollment and 820 Capitation Transactions
- 270 Eligibility Request and 271 Eligibility Response Transactions
- 837 Claim Transactions
- 835 Electronic FFS Claims Remittance Advice Transaction
- 276 Claim Status Request and 277 Claim Status Response Transactions
- *837 Encounter Transactions*
- 277 Unsolicited Claim Status Transaction (Encounters)

HIPAA Overview

The Administrative Simplification provisions of the Health Insurance Portability and Accountability Act of 1996 (HIPAA, Title II) require the federal Department of Health and Human Services to establish national standards for electronic health care transactions and national identifiers for providers, health plans, and employers. The Act also addresses the security and privacy of health data. The long-term purpose of these standards is to improve the efficiency and effectiveness of the nation's health care system by encouraging widespread use of standard electronic data interchanges in health care.

The intent of the law is that all electronic transactions for which standards are specified must be conducted according to the standards. These standards were reviewed through a process that included significant public and private sector input prior to publication in the Federal Register as Final Rules with legally binding implementation time frames.

Covered entities are required to accept transmissions in the standard format and must not delay a transaction or adversely affect an entity that wants to conduct standard transactions electronically. For HIPAA, both AHCCCS and its health plans are covered entities.

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Document Objective

This Encounter Companion Document provides information related to electronic submission of 837 Encounter Transactions to AHCCCS by contracted health plans. Three distinct encounter transaction formats are documented:

- 837 Professional
- 837 Dental
- 837 Institutional

For each of these formats, this Companion Guide tells health plans how to prepare and maintain a HIPAA compliant encounter interface, including information on populating encounter data elements for submission to AHCCCS.

Intended Users

Companion Documents are intended for the technical staffs of health plans and other entities that are responsible for electronic transaction exchanges. They also offer a statement of HIPAA Transaction and Code Set Requirements from an AHCCCS perspective.

Relationship to HIPAA Implementation Guides

Companion Documents are intended to supplement the HIPAA Implementation Guides for each of the HIPAA transactions. Rules for data format, content, and field values can be found in the Implementation Guides. This document describes the technical interface environment with AHCCCS in terms of data and processing implications for AHCCCS trading partners. Operational information involving connectivity requirements, protocols, and electronic interchange procedures is covered in other documents that are available from the AHCCCS Information Services Division (ISD) Customer Support Center. This Companion Document provides specific information on the fields and values required for transactions that are sent to or received from AHCCCS.

Companion Documents are intended to supplement but not to replace the standard Implementation Guides for each HPIAA Transaction Set. Information in Companion Documents is not intended to:

- Modify the definition, data condition, or use of any data element or segment in the standard Implementation Guides.
- Add any additional data elements or segments to the defined data set.
- Utilize any code or data values that are not valid in the standard Implementation Guides.
- Change the meaning or intent of any implementation specifications in the standard Implementation Guides.

Disclaimer

This Companion Document is a technical document describing the specific technical and procedural requirements for interfaces between AHCCCS and its trading partners. It does not supersede either the health plan contracts or the specific procedure manuals for various operational processes. If there are conflicts between this document and health plan contracts or operational procedure manuals, the contract or procedure manual will prevail.

Substantial effort has been taken to minimize information conflicts. However, AHCCCS, the Information Services Division, or its employees will not be liable or responsible for any errors or expenses resulting from the use of information in this document. If you believe there is an error in the document, please notify the AHCCCS Information Services Division immediately.

1.2 Contents of this Companion Document

Introduction	Section 1 provides general information on Companion Documents and HIPAA and outlines the information to be included in the remainder of the document.
Transaction Overview	Section 2 provides an overview of the transaction or transactions included in this Companion Document including information on: ▪ The purpose of the transaction(s) ▪ The standard Implementation Guide for the transaction(s) ▪ Replaced and impacted AHCCCS files and processes ▪ Transmission schedules
Technical Infrastructure	Section 3 provides a brief statement of the technical interfaces required for trading partners to communicate with AHCCCS via electronic transactions. The AHCCCS Encounter Reporting User Manual provides information on file names and procedures used in encounter submission. See especially Chapter Two, Encounter Reporting Guidelines.
Transaction Standards	Section 4 provides information relating to the transaction(s) in this Companion Document including: ▪ General HIPAA transaction standards ▪ Testing criteria and procedures ▪ Front end edits applicable to incoming transactions ▪ Procedures for generating and responding to required acknowledgment transactions ▪ Procedures for handling rejected transmissions and transactions
Transaction Specifications	Section 5 provides specific information relating to the transaction(s) in this Companion Document including: ▪ A statement of the purpose of transaction specifications between AHCCCS and other covered entities ▪ AHCCCS-specific data requirements for the transaction(s) at the data element level Transaction Specifications define in detail how HIPAA Transactions are formatted and populated for exchanges with AHCCCS.

2. 837 Encounter Transactions

2.1 Transaction Overview

Encounter Submission

The 837 Encounter Transaction has three separate formats for professional, dental, and institutional claims or encounters. Each of the formats has hundreds of data elements that describe medical services.
Encounter submission by health plans and encounter receipt and processing by AHCCCS are not changed by HIPAA mandates. What have changed significantly are encounter formats and code set requirements. AHCCCS "New Day" Encounters will now be submitted in 837 formats. New Day Encounters are encounters submitted to AHCCCS for the first time. They sometimes void or replace previously adjudicated encounters but they cannot correct or release encounters that are still in process.

In the HIPAA compliant environment, AHCCCS accepts encounters in the 837 formats and relies on a newly installed translator to bring them into its Prepaid Medical Management Information System (PMMIS). Once in PMMIS, the AHCCCS encounter correction process remains unchanged from the pre-HIPAA environment.

Encounter Processing

AHCCCS will use the Unsolicited 277 Encounter Status Transactions to inform submitting health plans of the status of each encounter. Encounter and service line status codes on the U277 Transaction are translated from codes used by PMMIS. "Pended" encounters in need of correction continue to be handled by correction procedures specific to AHCCCS and its health plans.

Processes Replaced or Impacted

Replaced Processes

- Pre-HIPAA Electronic New Day Encounter File

Impacted Processes

- Receipt of encounters from contracted health plans
- Notification to health plans of encounter statuses with Unsolicited 277 Encounter Status Transactions

The impacted processes will continue to function but will be changed so that they meet all X12N data and/or format compliance requirements.

2.2. Encounter Transactions

Purpose

Health plans pay claims from providers in their networks. AHCCCS pays health plans on a capitated per member per month basis with additional payments for high expenditure members via reinsurance. The Agency makes use of encounter data in capitation rate setting and in critical financial and utilization reports.

AHCCCS uses HIPAA compliant 837 Transactions for both fee for service claims and encounters. This Companion Document deals only with encounters.

Contracted health plans transmit 837 Encounter Transactions in batch mode through the AHCCCS File Transfer Protocol (FTP) Server. Batch submission accommodates large volumes of encounters from multiple health plans.

Standard Implementation Guides

The Standard Implementation Guides for Encounter Transactions are:

- 837 Health Care Claim: Professional (004010X098)
- 837 Health Care Claim: Dental (004010X097)
- 837 Health Care Claim: Institutional (004010X096)

For 837 Transactions, AHCCCS is incorporating all approved Addenda. Transmission Type Codes for production transactions that follow standards as modified by Addenda are:

- ASC X12N 837 Professional (004010X098A1)
- ASC X12N 837 Dental (004010X097A1)
- ASC X12N 837 Institutional (004010X096A1)

Related Specifications

In addition to 837 Encounter Transactions, AHCCCS is implementing Unsolicited 277 or U277 Encounter Status Transactions. AHCCCS sends U277 Transactions to encounter submitters in response to processed encounters with finalized or pended outcomes. Professional, dental, institutional, and drug encounters are included. The U277 Transaction has its own Companion Document.

3. Technical Infrastructure and Procedures

AHCCCS Data Center Communications Requirements

Trading partners connect to AHCCCS by going from the Internet through a Virtual Private Network (VPN) Tunnel to the AHCCCS File Transfer Protocol (FTP) Server. In standard software-to-hardware VPN connections, VPN client software is installed and configured on each machine at the client site that requires FTP access. Cisco Systems Software to establish provider computers as VPN Clients is available from the sources documented in the AHCCCS electronic encounter submission document. Detailed information on FTP and VPN setups also appears in that manual.

Technical Assistance and Help

The AHCCCS ISD Customer Support Center provides technical assistance related to questions about electronic data submission or data communications interfaces. All calls result in Ticket Number assignment and problem tracking. Contact information is:

- **Telephone Number:** (602) 417-4451
- **Hours:** 8:00 AM – 5:00 PM Arizona Time, Mondays through Fridays
- **Information required for initial call:**
  - Topic of Call (VPN setup, FTP procedures, 837 Encounter Transaction, etc.)
  - Name of caller
  - Organization of caller
  - Telephone number of caller
  - Nature of problem (connection, receipt status, etc.)
- **Information required for follow up call(s):**
  - Ticket Number assigned by the Customer Support Center

4. Transaction Standards

4.1 General Information

HIPAA Requirements

HIPAA standards are specified in Implementation Guides for each transaction set and in authorized Addenda. The second draft Addenda Documents for the three types of 837 Transactions have been published in final form in February 2003. In this Companion Document, AHCCCS uses 837 Transactions as modified by final Addenda.
For X12 Transactions, an overview of requirements specific to each transaction can be found in each Implementation Guide. Implementation Guides contain information related to:

- The format and content of interchanges and functional groups of transactions
- Code sets and values authorized for use in the transaction

For encounters, this Companion Document, in combination with the Implementation Guide, tells how to prepare data in HIPAA standard formats for submission to AHCCCS.

Size of Transmissions/ Batches

Transmission sizes are limited based on the number of segments/records recommended by HIPAA standards. There is no AHCCCS limit on file size for electronic encounter submission. HIPAA recommendations for the maximum file size of each transaction set are specified in the Implementation Guide and its authorized Addenda.

For the 837 Transaction, the Implementation Guide's recommendation is for a maximum of 5,000 CLM Claim Information Segments, generally equivalent to 5,000 claims or encounters. This does not mean that encounter submitters are limited to 5,000 encounters per submission. Multiple 837 Encounter Transactions of 5,000 encounters each can be submitted within a functional group and transmission.

4.2 Edits for Encounter Transactions

Overview of the Syntactical Edit Process

Edits performed by the AHCCCS translator on 837 Encounter Transactions ensure that incoming transactions comply with the standards documented in each transaction's HIPAA Implementation Guide. Only 837 Transactions of encounters that have passed translator edits can have their encounters translated and adjudicated. The translator's edits are prior to and in addition to edits performed by PMMIS. AHCCCS processes and procedures for resolution of encounters pended by PMMIS remain unchanged.

AHCCCS uses the 997 Functional Acknowledgement Transaction to acknowledge each functional group of 837 Transactions that has passed translator edits and the 824 Implementation Guide Reporting Transaction to inform 837 submitters of "syntactical" problems. Syntactical errors differ from "semantic" errors in that they involve data structures rather than meanings of data elements. In general, the AHCCCS translator handles syntactical edits and PMMIS handles semantic edits.

The 997 and 824 are ASC X12 Transactions that are not explicitly required by HIPAA rules but are available to perform acknowledgement and error notification functions electronically. The 997 is documented in Appendix B of every HIPAA Implementation Guide. The 824 has its own ASC X12 (but non-HIPAA) Implementation Guide. A final version of it is available from the Washington Publishing Company. Call Washington Publishing's Order Desk at (301) 949-9740 for information on payment procedures.

Four types of edits (in addition to preliminary edits that involve only ISA/IEA outer envelopes) are handled by the AHCCCS translator and reported on 824 Transactions. They are:

1. Integrity Edits
   This kind of edit validates the basic syntactical integrity of the incoming EDI file.

2. Implementation Guide-Requirements Edits
   This kind of edit involves requirements imposed by the transaction's HIPAA Implementation Guide, including validation of data element values specified in the Guide.

3. Balancing Edits
   Balancing verification requires that summary-level data be numerically consistent with corresponding detail level data, as defined in the transaction's Implementation Guide.

4. Inter-Segment Situation Edits
   Edits to validate inter-segment situations specified in the Implementation Guide (e.g., for accident claims, an Accident Date must be present).

In addition to carrying error codes, the 824 Transaction shows the relative location of erroneous data structures with error position designators. For a large transaction, each of the generic edit code values can be repeated in many code to element combinations.

In addition to carrying Data Element Syntax Error Codes, the 824 shows the relative location of erroneous elements with error position designators. For a large transaction, each of the ten values listed above could be repeated in many code to element combinations.

Standards for all of the above edits are based on HIPAA Implementation Guides and are not specific to AHCCCS. Other X12 trading partners can be expected to use the same conventions.

4.3 Data Interchange Conventions

Overview of Data Interchange

When receiving 837 Encounter Transactions from health plans, AHCCCS follows standards developed by the Accredited Standards Committee (ASC) of the American National Standards Institute (ANSI). These standards involve Interchange (ISA/IEA) and Functional Group (GS/GE) Segments or "outer envelopes". All 837 Transactions are enclosed in transmission level ISA/IEA envelopes and, within transmissions, functional group level GS/GE envelopes. The segments and data elements used in outer envelopes are documented in Appendix B1 of Implementation Guides.

Transaction Specifications that say how individual data elements are populated by AHCCCS on ISA/IEA and GS/GE envelopes appear in the table beginning on the next page. This document assumes that security considerations involving user identifiers, passwords, and encryption procedures are handled by the AHCCCS FTP Server and not through the ISA Segment.

The ISA/IEA Interchange Envelope, unlike most ASC X12 data structures, has fixed fields of a fixed length. Blank fields cannot be left out.

Sender and Receiver Identification Numbers in ISA and GS Segments are assigned in Trading Partner Tables maintained by AHCCCS.

Outer Envelope Specifications Table

Definitions of table columns follow:

Loop ID
The Implementation Guide's identifier for a data loop within a transaction. Always "NA" in this situation because segments in outer envelopes have segments and elements but not loops.

Segment ID
The Implementation Guide's identifier for a data segment.

Element ID
The Implementation Guide's identifier for a data element within a segment.

Element Name
A data element name as shown in the Implementation Guide. When the industry name differs from the Data Element Dictionary name, the more descriptive industry name is used.

Element Definition/Length
How the data element is defined in the Implementation Guide. For ISA and IEA Segments only, fields are of fixed lengths and are present whether or not they are populated. For this reason, field lengths are provided in this column after element definitions.

Valid Values
The data element values in the Implementation Guide that are used by AHCCCS.

Definition/Format
Definitions of valid values used by AHCCCS and additional information about AHCCCS data element requirements.

ISA/IEA INTERCHANGE CONTROL ENVELOPE SPECIFICATIONS						
Loop ID	**Seg ID**	**Element ID**	**Element Name**	**Element Definition/Length**	**Valid Values**	**Definition/Format**
ISA INTERCHANGE HEADER						
NA	ISA	ISA01	AUTHORIZATION INFORMATION QUALIFIER	Code to identify the type of information in the Authorization Information Element/2 Bytes	00	No Authorization Information Present
NA	ISA	ISA02	AUTHORIZATION INFORMATION	Information used for additional identification or authorization of the interchange sender or the data in the interchange; the type of information is set by the Authorization Information Qualifier/10 bytes		Leave field blank – not used by AHCCCS.
NA	ISA	ISA03	SECURITY INFORMATION QUALIFIER	Code to identify the type of information in the Security Information/2 bytes	00	No Security Information present
NA	ISA	ISA04	SECURITY INFORMATION	This field is used for identifying the security information about the interchange sender and the data in the interchange; the type of information is set by the Security Information Qualifier/10 bytes		Leave field blank – not used by AHCCCS.
NA	ISA	ISA05	INTERCHANGE ID QUALIFIER	Qualifier to designate the system/method of code structure used to designate the sender or receiver ID element being qualified/2 bytes	ZZ	Mutually Defined
NA	ISA	ISA06	INTERCHANGE SENDER ID	Identification code published by the sender for other parties to use as the receiver ID to route data to them; the sender always codes this value in the sender ID element/15 bytes		The Interchange Sender ID consists of a 3-byte acronym with the submitter's Tax ID.
NA	ISA	ISA07	INTERCHANGE ID QUALIFIER	Qualifier to designate the system/method of code structure used to designate the sender or receiver ID element being qualified/2 bytes	ZZ	Mutually Defined
NA	ISA	ISA08	INTERCHANGE RECEIVER ID	Identification code published by the receiver of the data; When sending, it is used by the sender as their sending ID, thus other parties sending to them will use this as a receiving ID to route data to them/15 bytes		"AHCCCS" followed by the nine-digit AHCCCS Federal Tax ID number ("AHCCCS866004791")
NA	ISA	ISA09	INTERCHANGE DATE	Date of the interchange/6 bytes		The Interchange Date in YYMMDD format
NA	ISA	ISA10	INTERCHANGE TIME	Time of the interchange/4 bytes		The Interchange Time in HHMM format
NA	ISA	ISA11	INTERCHANGE CONTROL STANDARDS IDENTIFIER	Code to identify the agency responsible for the control standard used by the message that is enclosed by the interchange header and trailer/1 character	U	U.S. EDI Community of ASC X12, TDCC, and UCS

ISA/IEA INTERCHANGE CONTROL ENVELOPE SPECIFICATIONS						
Loop ID	**Seg ID**	**Element ID**	**Element Name**	**Element Definition/Length**	**Valid Values**	**Definition/Format**
NA	ISA	ISA12	INTERCHANGE CONTROL VERSION NUMBER	This version number covers the interchange control segments/5 bytes	00401	Draft Standards for Trial Use Approved for Publication by ASC X12 Procedure Review Board through October 1997
NA	ISA	ISA13	INTERCHANGE CONTROL NUMBER	A control number assigned by the interchange sender/9 bytes		ISA13 must be unique within all transmissions (i.e., files) submitted to AHCCCS by the same entity. AHCCCS tracks this number to guard against duplicate file submissions. ISA13 must also be identical to the control number in Interchange Trailer element IEA02.
NA	ISA	ISA14	ACKNOWLEDGE-MENT REQUESTED	Code sent by the sender to request an Interchange Acknowledgement (TA1)/1 character	1	Interchange Acknowledgement Requested AHCCCS does not require TA1 Interchange Acknowledgement Segments from its trading partners. If trading partners send them, however, the AHCCCS translator will receive them and notify AHCCCS staff of their receipt.
NA	ISA	ISA15	USAGE INDICATOR	Code to indicate whether data enclosed is test, production or information/1 character	P or T	Production Data or Test Data
NA	ISA	ISA16	COMPONENT ELEMENT SEPARATOR	The delimiter value used to separate components of composite data elements/1 character	|	Trading partners can use any conventions they wish to establish separators or delimiters within transactions. The AHCCCS translator interprets separator values from their use in ISA Segments and in ISA16. Trading partners are free to adopt the values used by AHCCCS on outgoing transactions (see below). A “pipe” (the symbol above the backslash on most keyboards) is the value used by AHCCCS for component separation. Segment and element level delimiters do not require separate ISA elements to identify them.

ISA/IEA INTERCHANGE CONTROL ENVELOPE SPECIFICATIONS						
Loop ID	**Seg ID**	**Element ID**	**Element Name**	**Element Definition/Length**	**Valid Values**	**Definition/Format**
						Delimiter values, by definition, cannot be used as data, even within free-form messages. The following separator or delimiter values are used by AHCCCS on outgoing transactions and are available to encounter submitters: Segment Delimiter - "~' (tilde – hexadecimal value X"7E") Element Delimiter - "{" (left rounded bracket – hexadecimal value X"7B") Composite Component Delimiter (ISA16) - "|" (pipe – hexadecimal value X"7C") These values are used because they are not likely to occur within transaction data.
IEA INTERCHANGE TRAILER						
NA	IEA	IEA01	NUMBER OF INCLUDED FUNCTIONAL GROUPS	A count of the number of functional groups included in an interchange/5 bytes		The number of functional groups of transactions in the interchange
NA	IEA	IEA02	INTERCHANGE CONTROL NUMBER	A control number assigned by the interchange sender/9 bytes		A control number identical to the header-level Interchange Control Number in ISA13.

GS/GE FUNCTIONAL GROUP ENVELOPE SPECIFICATIONS							
Loop ID	**Seg ID**	**Element ID**	**Element Name**	**Element Definition/Length**	**Valid Value**	**Definition/Format**	**Source**
GS FUNCTIONAL GROUP HEADER							
NA	GS	GS01	FUNCTIONAL IDENTIFIER CODE	Code identifying a group of application related transaction sets	HC	Health Care Claim (837)	HIPAA Code Set
NA	GS	GS02	APPLICATION SENDER'S CODE	Code identifying party sending transmission; codes agreed to by trading partners		The Application Sender's Code consists of a 3-byte acronym with the AHCCCS Health Plan ID.	Transmission sender
NA	GS	GS03	APPLICATION RECEIVER'S CODE	Codes identifying party receiving transmission. Codes agreed to by trading partners		"AHCCCS" followed by the nine-digit AHCCCS Federal Tax ID number ("AHCCCS866004791")	Transmission sender
NA	GS	GS04	DATE	Date expressed as CCYYMMDD		The functional group creation date.	Transmission sender
NA	GS	GS05	TIME	Time on a 24-hour clock in HHMM format.		The functional group creation time.	Transmission sender
NA	GS	GS06	GROUP CONTROL NUMBER	Assigned number originated and maintained by the sender		A control number for the functional group of transactions.	Transaction sender
NA	GS	GS07	RESPONSIBLE AGENCY CODE	Code used in conjunction with Element GS08 to identify the issuer of the standard	X	Accredited Standards Committee X12	HIPAA Code Set
NA	GS	GS08	VERSION/ RELEASE/ INDUSTRY IDENTIFIER CODE	Code that identifies the version of the transaction(s) in the functional group		837D = 004010X097A1 837I = 004010X96A1 837P = 004010X98A1 AHCCCS uses Addenda versions of all HIPAA Transactions. This Version Number incorporates the final Addenda.	HIPAA Code Set
GE FUNCTIONAL GROUP TRAILER							
NA	GE	GE01	NUMBER OF TRANSACTION SETS INCLUDED	The number of transactions in the functional group ended by this trailer segment			Transmission sender
NA	GE	GE02	GROUP CONTROL NUMBER	Assigned number originated and maintained by the sender		This number must match the control number in GS06.	Transmission sender

4.4 Acknowledgement Procedures

Overview of Electronic Acknowledgment Processes

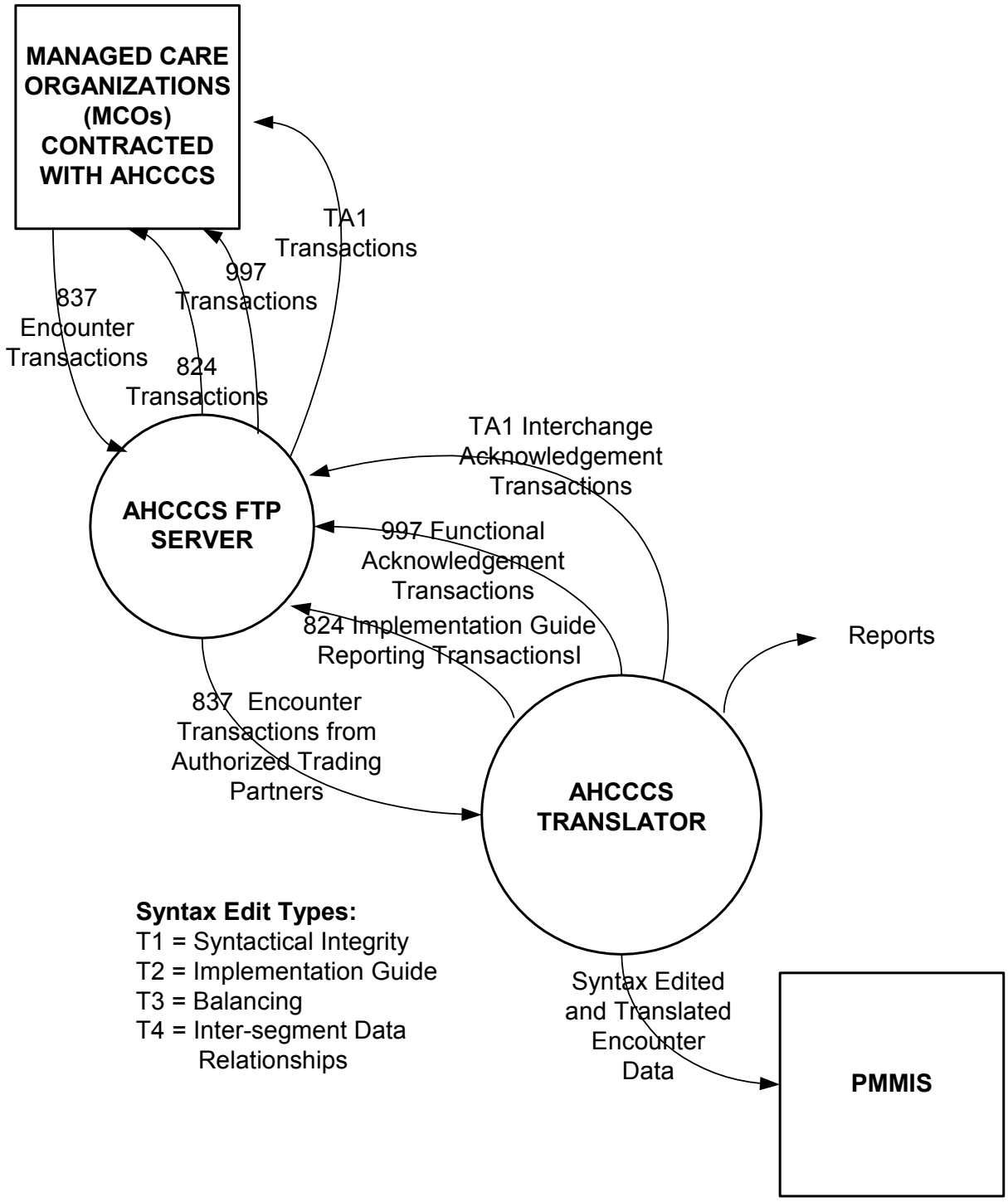
The diagram on the next page, AHCCCS Interchange Flow for 837 Encounter Transactions, shows how the AHCCCS translator accepts, acknowledges, and reports problems on 837 Encounters from health plans. The AHCCCS electronic acknowledgement and error reporting process affects all types of 837 Encounter Transactions (Professional, Dental, and Institutional).

As shown at the top of the diagram, encounter submitters transmit 837 Transactions to the AHCCCS File Transfer Protocol (FTP) Server. The AHCCCS translator uploads authorized electronic transmissions from the Server into the translator. At this point, the translator checks data in the ISA/IEA outer envelope of the interchange (i.e., transmission or file). It returns a TA1 Application Acknowledgement Segment to the claim submitter if there are errors in the outer envelope. When this happens, data within the transmission is not processed further.

For transmissions that are valid on the interchange level, the translator edits transactions and uses 824 Implementation Guide Reporting Transactions to report problems. The syntactical edits reported on the 824 are required to ensure that complex electronic transactions are assembled and formatted correctly. For syntactically valid functional groups of transactions, 997s are returned as electronic acknowledgements.

Finally comes the actual translation of syntactically valid data from the 837 Transaction to PMMIS. Elements from 837 Transactions are moved to PMMIS Tables for claim adjudication and reporting. Values of HIPAA code sets are converted to AHCCCS code set values and/or reformatted for use in claim adjudication and reporting.

AHCCCS Interchange Flow for 837 Encounter Transactions



4.5 Rejected Transmissions and Transactions

Overview of Rejection Process

Upon receiving an electronic transmission from an encounter submitter, the AHCCCS translator's first action is to check for presence and validity of data in the transaction's outer envelope of ISA and IEA Interchange Header and Trailer Segments. If ISA/IEA data is valid, processing continues. If the segments have errors, the entire file is rejected with a TA1 Interchange Acknowledgement Transaction with a descriptive error code. The submitter must correct the problem in the outer envelope and resubmit all transactions in the transmission.

Next come the translator's syntactical edits on the transaction or transactions within the outer envelope. When an incoming functional group of one or more 837 Transactions has passed the translator's syntactical edits, AHCCCS returns a 997 Functional Acknowledgement Transaction with a Functional Group Acknowledge Code (AK901) of "A" (Accepted) to signify acceptance. For functional groups with errors, one or more 824 Implementation Guide Reporting Transactions reject each 837 Transaction (ST through SE) within the functional group with an Application Acknowledgement Code (OTI01) beginning with "R" (Reject).

Any error detected by the translator results in rejection of the entire transmission, even when the transmission has multiple transactions, some good and some bad. For rejected transactions, AHCCCS makes use of standard 824 error location designators to identify each erroneous data structure. The translator reports all transaction errors that it can identify. It does not stop editing when it detects a problem.

5. Transaction Specifications

5.1 Transaction Specifications

Purpose

Transaction specifications are designed, in combination with the HIPAA Implementation Guides, to identify data to be transmitted between particular trading partners and to specify its type and format. This information supplements the requirements in HIPAA Transaction Implementation Guides. Data structures that are fully covered by the HIPAA Implementation Guide are not mentioned in this section.

Only transaction data with submission requirements specific to AHCCCS encounters is included. For example, the 2320 Other Subscriber Information Loop and the loops within it are used on AHCCCS X12 encounters to report, on one iteration, health plan adjudication information and, on additional iterations, adjudication information from other carriers that also contributed to payment. This AHCCCS usage is not discussed explicitly in the 837 Professional Implementation Guide but is covered in this Companion Document.

Relationship to HIPAA Implementation Guides

Transaction specifications are intended to supplement the data in the Implementation Guides for each transaction set with specific information pertaining to the trading partners using the transaction set.

The information in the Transaction Specifications is not intended to:

- Modify the definition, data condition, or use of any data element or segment in the standard Implementation Guides.
- Add any additional data elements or segments to the defined data set.
- Utilize any code or data values that are not valid in the standard Implementation Guides.
- Change the meaning or intent of any implementation specifications in the standard Implementation Guides.

5.2 Encounter Transaction Specifications – Professional 837 Encounters

Overview

837 Encounter Transactions from AHCCCS health plans contain data to enable AHCCCS to process and report on services to health plan members. The purposes of these Transaction Specifications are to identify critical data elements and data element values that AHCCCS needs in Encounter Transactions and to let health plans know how to populate encounter data for AHCCCS.

The specifications described in this section apply only to 837 Professional Encounter Transactions that health plans send to AHCCCS, not to claims that fee for service providers submit to AHCCCS. Only data elements that are used by AHCCCS in ways that require explanations that go beyond information in standard Implementation Guides are included.

General Transaction Specifications

Professional 837 Encounter Transaction Specifications that are not specific to an individual data element are discussed below.

- All Professional 837 Encounter Loops, Segments, and Elements are of variable length. Segments within loops and elements within segments occur only when data is present. There are no blank or null fields.

- For 837 Encounter Transactions, AHCCCS is considered the "destination payer". The destination payer is the payer that receives and adjudicates a claim or encounter even when (as with AHCCCS) there is no direct payment as a result of adjudication.

- On encounters submitted to AHCCCS, 837 loops, segments, and data elements that involve coordination of benefits with other payers are used in two ways:
  - To show payments made to medical providers by the submitting health plan.
  - To show payments made by third party carriers, including Medicare and commercial health insurance companies.

  One iteration of the 2320 Other Subscriber Information Loop (and all data subservient to the 2320 Loop) on Professional 837 Transactions is always for the submitting health plan and is always required. Up to nine additional situational iterations of the 2320 Loop are available for additional other payers.

- For all types of providers on Professional 837 Claims, primary provider identifiers (NM109) are Federal Tax ID numbers with an "FI" Qualifier (NM108). Secondary identifiers in Additional Identifier REF02 Elements are six-digit AHCCCS Provider IDs and two digit Location Codes with a REF01 Qualifier of "1D" (Medicaid Provider ID).

Transaction Specifications Table

The Professional 837 Encounter Transaction Specifications for individual data elements are shown in the table starting on the next page. Definitions of table columns follow.

Loop ID
The Implementation Guide's identifier for a data loop within a transaction.

Segment ID
The Implementation Guide's identifier for a data segment within a loop.

Element ID
The Implementation Guide's identifier for a data element within a segment.

Element Name
A data element name as shown in the Implementation Guide. When the Industry Name differs from the Data Element Dictionary name, the more descriptive Industry Name is used.

Element Definition
How the data element is defined in the Implementation Guide.

Valid Values
Data element values in the Implementation Guide that are used by AHCCCS.

Definition/Format
Definitions of valid values used by AHCCCS and additional information about AHCCCS data element requirements.

837 PROFESSIONAL ENCOUNTER TRANSACTION SPECIFICATIONS						
Loop ID	**Seg ID**	**Element ID**	**Element Name**	**Element Definition**	**Valid Values**	**Definition/Format**
1000A	NM1	NM109	Submitter Identifier	Code or number identifying the entity submitting the claim		Submitting health plans are identified by a six-character AHCCCS Health Plan ID, a three-character Transmission Submitter Number (TSN), and a one-character Input Mode ("2" [Adjudicated Encounter] or "6" [Denied Encounter]).
1000B	NM1	NM103	Receiver Name	Name of organization receiving the transaction	AHCCCS	The transaction receiver
1000B	NM1	NM108	Identification Code Qualifier	Code designating the system/method of code structure used for Identification Code	46	Electronic Transmitter Identification Number (ETIN)
1000B	NM1	NM109	Receiver Primary Identifier	Primary identification number for the receiver of the transaction	866004791	The AHCCCS Federal Tax ID
2000B	SBR	SBR09	Claim Filing Indicator Code	Code identifying type of claim	MC	Medicaid AHCCCS requests a "MC" value in this element in order to invoke translator edits that require Medicaid Provider Numbers with "1D" Qualifiers on "MC" claims or encounters.
2010BA	NM1	NM109	Subscriber Primary Identifier	Primary identification number of the subscriber to the coverage		AHCCCS Recipient ID
2010BB	NM1	NM103	Payer Name	Name identifying the payer organization	AHCCCS	The "destination payer" according to the Implementation Guide.
2010BB	NM1	NM109	Payer Identifier	Number identifying the payer organization	866004791	The AHCCCS Federal Tax Id Number
2300	CLM	CLM01	Patient Account Number	Unique identification number assigned by the provider to the claim patient to facilitate posting of payment information and identification of the billed claim		This is the Patient Account Number used by the provider that performed the service, not the number assigned by the health plan. For HIPAA, the maximum length of the field is 20 characters.
2300	CLM	CLM05-1	Facility Type Code	Code identifying the type of facility where services were performed; the first and second positions of the Uniform Bill Type code or the Place of Service code from the Electronic Media Claims National Standard Format		Place of Service is submitted at the encounter level but stored at the service line level on PMMIS Encounter Tables. Place of Service Codes submitted at the encounter level apply to all service lines unless overridden by a different Place of Service at the line level.
2300	CLM	CLM05-3	Claim Frequency Code	Code specifying the frequency of the claim This is the third position of the Uniform Billing Claim Form Bill Type	1 7 8	Original Replacement (Replacement of prior encounter) Void (Void/Cancel of prior encounter)

837 PROFESSIONAL ENCOUNTER TRANSACTION SPECIFICATIONS						
Loop ID	**Seg ID**	**Element ID**	**Element Name**	**Element Definition**	**Valid Values**	**Definition/Format**
2300	CLM	CLM20	Delay Reason Code	Code indicating the reason why a request was delayed	1 2 3 4 5 6 7 8 9 10 11	Proof of Eligibility Unknown or Unavailable Litigation Authorization Delays Delay in Certifying Provider Delay in Supplying Billing Forms Delay in Delivery of Custom-made Appliances Third Party Processing Delay Delay in Eligibility Determination Original Claim Rejected or Denied Due to a Reason Unrelated to the Billing Limitation Rules Administration Delay in the Prior Approval Process Other This data element is required when an encounter is submitted late (past the contracted date of filing limitations). If the reason for the delay is not specified in the list, enter “11” (Other).
2300	CN1	CN101	Contract Type Code	Code identifying a contract type	02 03 04 05 06 09	Per Diem Variable Per Diem Flat Capitated Percent Other One of the above values is required on all encounters to identify the servicing provider’s relationship to the health plan.
2300	AMT	AMT02	Total Purchased Service Amount	Amount of charges associated with the claim attributable to purchased services		Required if there are purchase service components to an encounter.
2300	REF	REF01	Reference Identification Qualifier	Code qualifying the reference identification	F8	Original Reference Number Required for replacement and void encounters (CLM05-3 = “7” or “8”).

837 PROFESSIONAL ENCOUNTER TRANSACTION SPECIFICATIONS						
Loop ID	**Seg ID**	**Element ID**	**Element Name**	**Element Definition**	**Valid Values**	**Definition/Format**
2300	REF	REF02	Claim Original Reference Number	Number assigned by a processor to identify a claim		For replacement and void encounters (CLM05-3 = “7” or “8”), the AHCCCS Claim Reference Number (CRN) of the prior encounter being replaced or voided.
2320	SBR	SBR01	Payer Responsibility Sequence Number Code	Code identifying the insurance carrier's level of responsibility for a payment of a claim	P S T	Primary Secondary Tertiary The 2320 Other Subscriber Information Loop can occur up to ten times for up to ten payers other than AHCCCS. One iteration of the loop is always for the individual health plan that submits the encounter. Additional 2320 Loops are for payers other than the member’s health plan. They can have any responsibility sequence and may be for subscribers other than the health plan member (e.g., family members). The 2320 Loop is an “umbrella loop” that contains within it Loops 2330A through 2330E. All of these loops can be repeated as needed for each payer.
2320	CAS	CAS01	Claim Adjustment Group Code	Code identifying the general category of payment adjustment		Enter the code value in the Implementation Guide that best describes the reason for any difference between the header level Charged Amount and the Paid Amount. The use of the CAS segment at the claim header is discouraged for professional encounters. The adjustments should appear at the line level (2430 Loop).
2320	CAS	CAS02	Adjustment Reason Code	Code that indicates the reason for the adjustment	Many Code Set Values	Hundreds of Adjustment Reason Code values are maintained on the Washington Publishing Company’s Web Site (www.wpc-edi.com). Submit the code value or values that best describe the reason for the difference between the Charged Amount and the Paid Amount. These are the same Adjustment Reason Codes that appear on the 835 Claim Remittance Advice Transaction. The 837 Transaction is designed in the Implementation

837 PROFESSIONAL ENCOUNTER TRANSACTION SPECIFICATIONS						
Loop ID	**Seg ID**	**Element ID**	**Element Name**	**Element Definition**	**Valid Values**	**Definition/Format**
						Guide to pick them up from the other payer's 835. If a health plan transmits 835 Remittance Advice Transactions to providers, data from these transactions can be the source of the Adjustment Reason Code(s) on the initial health plan iteration of the 2320 Loop. For additional other carriers, the Adjustment Reason Code(s) can be transferred (or generated by the health plan) if available. The "adjustment trio", consisting of Adjustment Reason Code, Adjustment Amount, and Adjustment Quantity, occurs up to six times within each CAS Segment.
2320	CAS	CAS03	Adjustment Amount	Adjustment amount for the associated reason code		The difference between the encounter level Charged Amount and Paid Amount associated with the Adjustment Reason Code in CAS02.
2320	CAS	CAS04	Adjustment Quantity	Numeric quantity associated with the related reason code for coordination of benefits		The difference between the billed and paid units of service for all service lines when the difference is the result of claim level adjudication and is associated with the Adjustment Reason Code in CAS02.
2320	AMT	AMT01	COB Payer Paid Amount Qualifier	Code qualifying the COB Payer Paid Amount	D	
2320	AMT	AMT02	COB Payer Paid Amount	The amount paid by the payer on this claim		The encounter level Amount Paid by the payer of this 2320 Loop. On health plan 2320 Loops, this is the encounter level Health Plan Paid Amount.
2320	AMT	AMT01	COB Allowed Amount Qualifier	Code qualifying the COB Allowed Amount	B6	The encounter level Allowed Amount for the payer of the 2320 Loop.
2320	AMT	AMT02	COB Allowed Amount	The maximum amount determined by the payer as being 'allowable' under the provisions of the contract prior to the determination of actual payment		The encounter level Allowed Amount for the payer of this 2320 Loop. For health plan 2320 Loops, the Allowed Amount is always greater than zero.

837 PROFESSIONAL ENCOUNTER TRANSACTION SPECIFICATIONS						
Loop ID	**Seg ID**	**Element ID**	**Element Name**	**Element Definition**	**Valid Values**	**Definition/Format**
2320	DMG	DMG02	Other Insured Birth Date	The birth date of the additional insured individual		The “other subscriber’s” birth date in CCYYMMDD format. This is the birth date of the subscriber (who may or may not be the same as the member).
2320	MOA	MOA02	Claim HCPCS Payable Amount	Sum of payable line item amounts for HCPCS codes billed on this claim		The Medicare Outpatient Adjudication MOA Segment is required if data for it is available from an electronic remittance advice (835 Transaction). This segment is used for outpatient adjudication Information, including standard HIPAA Remark Codes, generated by Medicare or another carrier. In this context, all professional services are considered outpatient. All data elements within the MOA Segment are situational. They reflect adjudication by Medicare or another payer and should be included if available to the health plan. MOA02 is the amount paid by HCPCS Procedure Code for outpatient services.
2330A	NM1	NM109	Other Insured Identifier	An identification number, assigned by the third party payer, to identify the additional insured individual		In the health plan 2320 Loop, the member’s AHCCCS ID. In subsequent 2320 Loops, the Subscriber ID assigned by the other payer.
2330B	NM1	NM109	Other Payer Primary Identifier	An identification number for the other payer		In the health plan 2320 Loop, the health plan’s AHCCCS ID and TSN. In additional 2320 Loops, any identification number assigned by the health plan to the other payer in this required element. AHCCCS will not perform validity edits on this identifier for payers other than contracted health plans.
2230B	REF	REF01	Reference Identification Qualifier	Code qualifying the Reference Identification	F8	Original Reference Number
2330B	REF	REF02	Other Payer Secondary Identifier	Additional identifier for the other payer organization		The health plan or other payer’s Claim Number for the claim that generated this encounter.

837 PROFESSIONAL ENCOUNTER TRANSACTION SPECIFICATIONS						
Loop ID	**Seg ID**	**Element ID**	**Element Name**	**Element Definition**	**Valid Values**	**Definition/Format**
2400	SV1	SV101-1	Product or Service ID Qualifier	Code identifying the type/source of the descriptive number used in Product/Service ID	HC	Health Care Financing Administration Common Procedural Coding System (HCPCS) Codes A variety of additional qualifier values are listed in the Implementation Guide, including qualifiers for NDC Drug and HIEC Home Infusion Codes. Alternative code sets are available if AHCCCS adopts them in the future.
2400	SV1	SV101-3	Procedure Modifier	This identifies special circumstances related to the performance of the service		The first Procedure Code Modifier submitted by the provider to the health plan.
2400	SV1	SV101-4	Procedure Modifier	This identifies special circumstances related to the performance of the service		The second Procedure Code Modifier submitted by the provider to the health plan.
2400	SV1	SV101-5	Procedure Modifier	This identifies special circumstances related to the performance of the service		The third Procedure Code Modifier submitted by the provider to the health plan.
2400	SV1	SV101-6	Procedure Modifier	This identifies special circumstances related to the performance of the service		The fourth Procedure Code Modifier submitted by the provider to the health plan.
2400	SV1	SV111	EPSDT Indicator	An indicator of whether or not Early and Periodic Screening for Diagnosis and Treatment of children services are involved with this detail line	Y	Yes, the service is the result of an EPSDT referral Required if a Medicaid service is the result of a screening referral. This service referenced by this service line element differs from the data on the referral itself in the encounter level EPSDT CRC Segment. This new segment has been introduced by the 837 Professional Addenda. SV111 indicates a service that results from an EPSDT referral, not the original EPSDT evaluation.
2400	AMT	AMT01	Amount Qualifier	Code to qualify amount	AAE	Approved Amount
2400	AMT	AMT02	Approved Amount	Monetary amount		The payment amount approved by the health plan

837 PROFESSIONAL ENCOUNTER TRANSACTION SPECIFICATIONS						
Loop ID	**Seg ID**	**Element ID**	**Element Name**	**Element Definition**	**Valid Values**	**Definition/Format**
2400	PS1	PS101	Purchased Service Provider Identifier	The provider number of the entity from which service was purchased		The PS101 element is for the provider identification number, the ID of the provider "from which service was purchased", The PS1 Segment is required on service lines that involve purchased services/tests if the ID and/or Amount are different from the information given at the claim level (Loop 2310C). For purchased service lines, including transplants, enter the AHCCCS Provider ID and Location Code.
2430	SVD	SVD01	Other Payer Primary Identifier	An identification number for the other payer		According to this Implementation Guide, the 2430 Loop is "required if claim has been previously adjudicated by payer identified in Loop 2330B and service line has adjustments applied to it." This number in this field needs to match NM109 in the Loop 2330B that identifies the other payer.
2430	CAS	CAS01	Claim Adjustment Group Code	Code identifying the general category of payment adjustment	CO CR OA PI PR	Contractual Obligations Correction and Reversals Other Adjustments Payer Initiated Reductions Patient Responsibility Required if the payer identified in loop 2330B made line level adjustments that caused the amount paid to differ from the amount originally charged. In this situation, enter the code value that best describes the reason for the different between the Charged Amount and the Paid Amount for this service line. The "Adjustment Trio" of the Adjustment Reason, Amount, and Quantity can occur up to six times per CAS Segment and CAS Segments have up to 99 iterations at the service line level. Five hundred and ninety-four Claim Adjustment Codes for the health plan and other carrier can be accommodated.

837 PROFESSIONAL ENCOUNTER TRANSACTION SPECIFICATIONS						
Loop ID	**Seg ID**	**Element ID**	**Element Name**	**Element Definition**	**Valid Values**	**Definition/Format**
2430	CAS	CAS02	Adjustment Reason Code	Code that indicates the reason for the adjustment	Many Code Set Values	Hundreds of Adjustment Reason Code values are maintained on the Washington Publishing Company's Web Site (www.wpc-edi.com). Enter the code value that best describes the reason for the difference between the Service Line Charged Amount and the Paid Amount. These are the same Adjustment Reason Codes that appear on the 835 Claim Remittance Advice Transaction. The "adjustment trio" of Adjustment Reason Code, Adjustment Amount, and Adjustment Quantity occur up to six times within the CAS Segment.
2430	CAS	CAS03	Adjustment Amount	Adjustment amount for the associated reason code		The difference between the service line level Charged Amount and Paid Amount associated with the Adjustment Reason Code in CAS02.
2430	CAS	CAS04	Adjustment Quantity	Numeric quantity associated with the related reason code for coordination of benefits		The difference between the billed and paid units of service at the service line level when the difference is the result of line level adjudication and is associated with the Adjustment Reason Code in CAS02.

5.3 Encounter Transaction Specifications – Dental 837 Encounters

Overview

837 Encounter Transactions from AHCCCS health plans contain data to enable AHCCCS to process and report on services to health plan members. The purposes of these Transaction Specifications are to identify critical data elements and data element values that AHCCCS needs in Encounter Transactions and to let health plans know how to populate encounter data for AHCCCS.

The specifications in this section apply only to 837 Dental Encounter Transactions that health plans send to AHCCCS, not to claims that fee for service providers submit to AHCCCS. Only data elements that are used by AHCCCS in ways that require explanations that go beyond information in standard Implementation Guides are included.

General Transaction Specifications

Dental 837 Encounter Transaction specifications that are not specific to a particular data element are discussed below.

- All Dental 837 Encounter Loops and Segments are of variable length. Segments within loops and elements within segments occur only when data is present. There are no blank or null fields. In some situations, zero field values are acceptable.

- For 837 Encounter Transactions, AHCCCS is considered the "destination payer". The destination payer is the payer that receives and adjudicates a claim or encounter even when (as with AHCCCS) there is no direct payment as a result of adjudication.

- On encounters submitted to AHCCCS, 837 loops, segments, and data elements that involve coordination of benefits with other payers are used in two ways:
  - To show payments made to providers by the submitting health plan.
  - To show payments made by third party carriers, including Medicare and commercial health insurance companies.

  The health plan iteration of the 2320 Other Subscriber Information Loop (and all data subservient to the 2320 Loop) on Dental 837 Transactions is always for the sending health plan. A health plan loop is required. Up to nine situational iterations of the 2320 Loop are available for additional other payers.

- Although the Dental 837 Transaction can be used to pre-approve dental

services, AHCCCS does not use it in this manner and does not expect pre-approval data on dental encounters.

- For all types of providers on Dental 837 Claims, primary provider identifiers (NM109) are Federal Tax ID numbers with an "FI" Qualifier (NM108). Secondary identifiers in Additional Identifier REF02 Elements are six-digit AHCCCS Provider IDs and two digit Location Codes with a REF01 Qualifier of "1D" (Medicaid Provider ID).

Transaction Specifications Table

The Dental 837 Encounter Transaction Specifications for individual data elements are shown in the table starting on the next page. Definitions of table columns follow.

Loop ID
The Implementation Guide's identifier for a data loop within a transaction.

Segment ID
The Implementation Guide's identifier for a data segment within a loop.

Element ID
The Implementation Guide's identifier for a data element within a segment.

Element Name
A data element name as shown in the Implementation Guide. When the industry name differs from the Data Element Dictionary name, the more descriptive industry name is used.

Element Definition
How the data element is defined in the Implementation Guide.

Valid Values
Data element values in the Implementation Guide that are used by AHCCCS.

Definition/Format
Definitions of valid values used by AHCCCS and additional information about AHCCCS data element requirements.

837 DENTAL ENCOUNTER TRANSACTION SPECIFICATIONS						
Loop ID	**Seg ID**	**Element ID**	**Element Name**	**Element Definition**	**Valid Values**	**Definition/Format**
1000A	NM1	NM109	Submitter Identifier	Code or number identifying the entity submitting the claim		Submitting health plans are identified by a six-character AHCCCS Health Plan ID, a three-character Transmission Submitter Number (TSN), and a one-character Input Mode ("2" [Adjudicated Encounter] or "6" [Denied Encounter]).
1000B	NM1	NM103	Receiver Name	Name of organization receiving the transaction	AHCCCS	The transaction receiver
1000B	NM1	NM108	Identification Code Qualifier	Code designating the system/method of code structure used for Identification Code	46	Electronic Transmitter Identification Number (ETIN)
1000B	NM1	NM109	Receiver Primary Identifier	Primary identification number for the receiver of the transaction	866004791	AHCCCS Federal Tax ID
2000B	SBR	SBR09	Claim Filing Indicator Code	Code identifying type of claim	MC	Medicaid AHCCCS requests a "MC" value in this element in order to invoke translator edits that require Medicaid Provider Numbers with "1D" Qualifiers on "MC" claims or encounters.
2010BA	NM1	NM109	Subscriber Primary Identifier	Primary identification number of the subscriber to the coverage		AHCCCS Recipient ID
2010BB	NM1	NM103	Payer Name	Name identifying the payer organization	AHCCCS	The name of the "destination payer" according to the Implementation Guide.
2010BB	NM1	NM109	Payer Identifier	Number identifying the payer organization	866004791	The AHCCCS Federal Tax ID
2300	CLM	CLM01	Patient Account Number	Unique identification number assigned by the provider to the claim patient to facilitate posting of payment information and identification of the billed claim		The Patient Account Number maintained by the provider that submitted the claim to the healthy plan that generated this encounter.
2300	CLM	CLM05-1	Facility Type Code	Code identifying the type of facility where services were performed; the first and second positions of the Uniform Bill Type code or the Place of Service code from the Electronic Media Claims National Standard Format		Code values are listed in the Implementation Guide and in the Addendum for the 837 Dental Transaction. The Addendum states that "only codes contained in the document available from code source 237 are to be supported in this transaction and take precedence over any and all codes listed here." Code Source 237 is CMS. The Implementation Guide provides an address, Web Site, and contact person.

837 DENTAL ENCOUNTER TRANSACTION SPECIFICATIONS						
Loop ID	**Seg ID**	**Element ID**	**Element Name**	**Element Definition**	**Valid Values**	**Definition/Format**
2300	CLM	CLM05-3	Claim Submission Reason Code	Code identifying reason for claim submission	1 7 8	Original Replacement (Replacement of prior claim) Void (Void/Cancel of prior claim)
2300	CLM	CLM20	Delay Reason Code	Code indicating the reason why a request was delayed	1 2 3 4 5 6 7 8 9 10 11	Proof of Eligibility Unknown or Unavailable Litigation Authorization Delays Delay in Certifying Provider Delay in Supplying Billing Forms Delay in Delivery of Custom-made Appliances Third Party Processing Delay Delay in Eligibility Determination Original Claim Rejected or Denied Due to a Reason Unrelated to the Billing Limitation Rules Administration Delay in the Prior Approval Process Other This data element is required when an encounter is submitted late (after the contracted date of filing limitations). If the reason for the delay is not specified in the list, enter “11” (Other).
2300	CN1	CN101	Contract Type Code	Code identifying a contract type	02 03 04 05 06 09	Per Diem Variable Per Diem Flat Capitated Percent Other One of the above values is required on all encounters to identify the servicing provider’s relationship to the health plan.
2300	REF	REF01	Reference Identification Qualifier	Code qualifying the reference identification	F8	Original Reference Number Required for replacement and void encounters (CLM05-3 = “7” or “8”).

837 DENTAL ENCOUNTER TRANSACTION SPECIFICATIONS						
Loop ID	**Seg ID**	**Element ID**	**Element Name**	**Element Definition**	**Valid Values**	**Definition/Format**
2300	REF	REF02	Claim Original Reference Number	Number assigned by a processor to identify a claim		For replacement and void encounters, the AHCCCS Claim Reference Number (CRN) of the prior encounter being replaced or voided.
2320	SBR	SBR01	Payer Responsibility Sequence Number Code	Code identifying the insurance carrier's level of responsibility for a payment of a claim	P or S or T	Primary or Secondary or Tertiary The 2320 Other Subscriber Information Loop can occur up to ten times for up to ten payers other than AHCCCS. One iteration of the loop is always for the individual health plan that submits the encounter. 2320 Loops in addition to the health plan loop are for payers other than the member's health plan. They can have any responsibility sequence and may be for subscribers other than the health plan member (e.g., family members). The 2320 Loop is an "umbrella loop" that contains within it Loops 2330A through 2330E. All of these loops can be repeated as needed for each payer.
2320	CAS	CAS01	Claim Adjustment Group Code	Code identifying the general category of payment adjustment		Enter the code value in the Implementation Guide that best describes the reason for any difference between the Charged Amount and the Paid Amount. The use of the CAS segment at the claim header is discouraged for professional encounters. The adjustments should appear at the line level (2430 Loop).

837 DENTAL ENCOUNTER TRANSACTION SPECIFICATIONS						
Loop ID	**Seg ID**	**Element ID**	**Element Name**	**Element Definition**	**Valid Values**	**Definition/Format**
2320	CAS	CAS02	Adjustment Reason Code	Code that indicates the reason for the adjustment	Many Code Set Values	Hundreds of Adjustment Reason Code values are maintained on the Washington Publishing Company's Web Site (www.wpc-edi.com). Submit the code value or values that best describes the reason for the difference between the Charged Amount and the Paid Amount. These are the same Adjustment Reason Codes that appear on the 835 Claim Remittance Advice Transaction. The 837 Transaction is designed to pick them up from the other payer's 835. If a health plan transmits 835 Remittance Advice Transactions to providers, data from these transactions can be the source of the Adjustment Reason Code(s) on the initial health plan iteration of the 2320 Loop. For subsequent other carriers, the Adjustment Reason Code(s) can be transferred (or generated by the health plan) if available. The "adjustment trio", consisting of Adjustment Reason Code, Adjustment Amount, and Adjustment Quantity, occurs up to six times within each CAS Segment.
2320	CAS	CAS03	Adjustment Amount	Adjustment amount for the associated reason code		The difference between the encounter level Charged Amount and Paid Amount associated with the Adjustment Reason Code in CAS02.
2320	CAS	CAS04	Adjustment Quantity	Numeric quantity associated with the related reason code for coordination of benefits		The difference between the billed and paid units of service for all service lines when the difference is the result of claim level adjudication and is associated with the Adjustment Reason Code in CAS02.
2320	AMT	AMT01	COB Payer Paid Amount Qualifier	Code qualifying the COB Payer Paid Amount	D	
2320	AMT	AMT02	Payer Paid Amount	The amount paid by the payer on this claim		The encounter level Amount Paid by the payer of this 2320 Loop. On health plan 2320 Loops, this is the encounter level Health Plan Paid Amount.
2320	AMT	AMT01	COB Allowed Amount Qualifier	Code qualifying the COB Allowed Amount	B6	The encounter level Allowed Amount by the payer of this 2320 Loop.

837 DENTAL ENCOUNTER TRANSACTION SPECIFICATIONS						
Loop ID	**Seg ID**	**Element ID**	**Element Name**	**Element Definition**	**Valid Values**	**Definition/Format**
2320	AMT	AMT02	Allowed Amount	The maximum amount determined by the payer as being 'allowable' under the provisions of the contract prior to the determination of actual payment		The encounter level Allowed Amount for the payer of this 2320 Loop. For the health plan 2320 Loop, the Allowed Amount is always greater than zero.
2320	DMG	DMG02	Other Insured Birth Date	The birth date of the additional insured individual		The “other subscriber’s” birth date in CCYYMMDD format. This DMG Segment is not needed in the health plan 2320 Loop. In additional other payer loops, this is the birth date of the subscriber (who may or may not be the same as the member).
2330A	NM1	NM109	Other Insured Identifier	An identification number, assigned by the third party payer, to identify the additional insured individual		In the health plan 2320 Loop, the member’s AHCCCS ID. In additional 2320 Loops, the Subscriber ID assigned by the other payer.
2330B	NM1	NM109	Other Payer Primary Identifier	An identification number for the other payer		In the health plan 2320 Loop, the health plan’s AHCCCS ID and TSN. In additional 2320 Loops, any identification number assigned by the health plan to the other payer in this required element. AHCCCS will not perform validity edits on this identifier.
2230B	REF	REF01	Reference Identification Qualifier	Code qualifying the Reference Identification	F8	Original Reference Number
2330B	REF	REF02	Other Payer Secondary Identifier	Additional identifier for the other payer organization		The health plan or other payer’s Claim Number for the claim.
2400	SV3	SV301-2	Procedure Code	Code identifying the procedure, product or service		Dental Procedure Code
2400	SV3	SV301-3	Procedure Modifier	This identifies special circumstances related to the performance of the service		First Dental Procedure Modifier On dental encounters and claims, Procedure Modifiers must be ADA Dental Procedure Modifiers, not non-dental HCPCS Modifiers. At this time, ADA Modifiers are not finalized. Do not submit until they are available.
2400	SV3	SV301-4	Procedure Modifier	This identifies special circumstances related to the performance of the service		Second Dental Procedure Modifier See SV301-3

837 DENTAL ENCOUNTER TRANSACTION SPECIFICATIONS						
Loop ID	**Seg ID**	**Element ID**	**Element Name**	**Element Definition**	**Valid Values**	**Definition/Format**
2400	SV3	SV301-5	Procedure Modifier	This identifies special circumstances related to the performance of the service		Third Dental Procedure Modifier See SV301-3
2400	SV3	SV301-6	Procedure Modifier	This identifies special circumstances related to the performance of the service		Fourth Dental Procedure Modifier See SV301-3
2400	SV3	SV306	Procedure Count	Number of Procedures		This element is for the service units reported by the provider to the health plan. The units reported by the health plan to AHCCCS are captured in loop 2430.
2400	AMT	AMT01	Amount Qualifier	Code to qualify amount	AAE	Approved Amount
2400	AMT	AMT02	Approved Amount	Monetary amount		The payment amount approved by the health plan
2420B	NM1	NM109	Other Payer Referral Number	The non-destination (COB) payer's service line level referral number		The other payer's identification number. It must be the same as a payer's ID Number in a claim level 2330B Loop.
2430	SVD	SVD01	Other Payer Primary Identifier	An identification number for the other payer		According to this Implementation Guide, the 2430 Loop is "required if claim has been previously adjudicated by payer identified in Loop 2330B and service line has adjustments applied to it." This number in this field needs to match NM109 in the Loop 2330B that identifies the other payer.

837 DENTAL ENCOUNTER TRANSACTION SPECIFICATIONS						
Loop ID	**Seg ID**	**Element ID**	**Element Name**	**Element Definition**	**Valid Values**	**Definition/Format**
2430	CAS	CAS01	Claim Adjustment Group Code	Code identifying the general category of payment adjustment	CO CR OA PI PR	Contractual Obligations Correction and Reversals Other Adjustments Payer Initiated Reductions Patient Responsibility Required if the payer identified in loop 2330B made line level adjustments that caused the amount paid to differ from the amount originally charged. In this situation, enter the code value that best describes the reason for the different between the Charged Amount and the Paid Amount for this service line. The “Adjustment Trio” of Adjustment Reason, Amount, and Quantity can occur up to six times per CAS Segment and CAS Segments have up to 99 iterations at the service line level. Five hundred and ninety-four Claim Adjustment Codes for the health plan and other carriers can be accommodated.
2430	CAS	CAS02	Adjustment Reason Code	Code that indicates the reason for the adjustment	Many Code Set Values	Hundreds of Adjustment Reason Code values are maintained on the Washington Publishing Company’s Web Site (www.wpc-edi.com). Enter the code value that best describes the reason for the difference between the Service Line Charged Amount and the Paid Amount. These are the same Adjustment Reason Codes that appear on the 835 Claim Remittance Advice Transaction.
2430	CAS	CAS03	Adjustment Amount	Adjustment amount for the associated reason code		The difference between the service line level Charged Amount and Paid Amount associated with the Adjustment Reason Code in CAS02.
2430	CAS	CAS04	Adjustment Quantity	Numeric quantity associated with the related reason code for adjustment of benefits		The difference between the billed and paid units of service at the service line level when the difference is the result of line level adjudication and is associated with the Adjustment Reason Code in CAS02.

5.4 Encounter Transaction Specifications – Institutional 837 Encounters

Overview

837 Encounter Transactions from AHCCCS health plans contain data to enable AHCCCS to process and report on services to health plan members. The purposes of these Transaction Specifications are to identify critical data elements and data element values that AHCCCS needs in Encounter Transactions and to let health plans know how to populate encounter data for AHCCCS.

The specifications in this section apply only to 837 Institutional Encounter Transactions that health plans send to AHCCCS, not to claims that fee for service providers submit to AHCCCS. Only data elements that are used by AHCCCS in ways that require explanations that go beyond information in standard Implementation Guides are included.

General Transaction Specifications

Institutional 837 Encounter Transaction Specifications that are not specific to an individual data element are discussed below.

- With the exception of data elements in the Transaction Header Segment, all Institutional 837 Encounter Loops and Segments are of variable length. Segments within loops and elements within segments occur only when data is present. There are no blank or null fields. In some situations, zero field values are acceptable.

- For 837 Encounter Transactions, AHCCCS is considered the "destination payer". The destination payer is the payer that receives and adjudicates a claim or encounter even when (as with AHCCCS) there is no direct payment as a result of adjudication.

- On encounters submitted to AHCCCS, 837 loops, segments, and data elements that involve coordination of benefits with other payers are used in two ways:
  - To show payments made to medical providers by the sending health plan.
  - To show payments made by third party carriers, including Medicare and commercial health insurance companies.

  The health plan iteration of the 2320 Other Subscriber Information Loop (and all data subservient to the 2320 Loop) on Institutional 837 Transactions is always for the sending health plan. A health plan loop is required. Up to nine situational iterations of the 2320 Loop are available for additional other payers.

- For all types of providers on Institutional 837 Claims, primary provider identifiers (NM109) are Federal Tax ID numbers with an "FI" Qualifier (NM108). Secondary identifiers in Additional Identifier REF02 Elements are six-digit AHCCCS Provider IDs and two digit Location Codes with a REF01 Qualifier of "1D" (Medicaid Provider ID).

Transaction Specifications Table

The Institutional 837 Encounter Transaction Specifications for individual data elements are shown in the table starting on the next page. Definitions of table columns follow.

Loop ID
The Implementation Guide's identifier for a data loop within a transaction.

Segment ID
The Implementation Guide's identifier for a data segment within a loop.

Element ID
The Implementation Guide's identifier for a data element within a segment.

Element Name
A data element's name as shown in the Implementation Guide. When the Industry Name differs from the Data Element Dictionary name, the more descriptive Industry Name is used.

Element Definition
How the data element is defined in the Implementation Guide.

Valid Values
Data element values in the Implementation Guide that are used by AHCCCS.

Definition/Format
Definitions of valid values used by AHCCCS and additional information about AHCCCS data element requirements.

837 INSTITUTIONAL ENCOUNTER TRANSACTION SPECIFICATIONSS						
Loop ID	**Segt ID**	**Element ID**	**Element Name**	**Element Definition**	**Valid Values**	**Definition/Format**
1000A	NM1	NM109	Submitter Identifier	Code or number identifying the entity submitting the claim		Submitting health plans are identified by a six-character AHCCCS Health Plan ID, a three-character Transmission Submitter Number (TSN), and a one-character Input Mode (“2” [Adjudicated Encounter] or “6” [Denied Encounter]).
1000B	NM1	NM103	Receiver Name	Name of organization receiving the transaction	AHCCCS	The transaction receiver
1000B	NM1	NM108	Information Receiver Identification Number	The identification number of the individual or organization who expects to receive information in response to a query	46	Electronic Transmitter Identification Number (ETIN)
1000B	NM1	NM109	Receiver Primary Identifier	Primary identification number for the receiver of the transaction	866004791	AHCCCS Federal Tax ID
2000B	SBR	SBR09	Claim Filing Indicator Code	Code identifying type of claim	MC	Medicaid AHCCCS requests a “MC” value in this element in order to invoke translator edits that require Medicaid Provider Numbers with “1D” Qualifiers on “MC” claims or encounters.
2010BA	REF	REF01	Reference Identification Qualifier	Code qualifying the reference identification	MI	Member Identification Number
2010BA	REF	REF02	Subscriber Supplemental Identifier	Identifies another or additional distinguishing code number associated with the subscriber		The member’s AHCCCS ID
2010BC	NM1	NM103	Payer Name	Name identifying the payer organization	AHCCCS	The “destination payer” according to the Implementation Guide.
2010BC	NM1	NM109	Payer Identifier	Number identifying the payer organization	866004791	The AHCCCS Tax ID Number
2300	CLM	CLM01	Patient Account Number	Unique identification number assigned by the provider to the claim patient to facilitate posting of payment information and identification of the billed claim		This is the Patient Account Number used by the provider that performed the service, not the number assigned by the health plan. For HIPAA, the maximum length of the field is 20 characters.
2300	CLM	CLM05-1	Facility Type Code	Code identifying the type of facility where services were performed; the first and second positions of the Uniform Bill Type		The first two characters of the UB Type of Bill field on institutional encounters.

837 INSTITUTIONAL ENCOUNTER TRANSACTION SPECIFICATIONSS						
Loop ID	**Segt ID**	**Element ID**	**Element Name**	**Element Definition**	**Valid Values**	**Definition/Format**
				code or the Place of Service code from the Electronic Media Claims National Standard Format		
2300	CLM	CLM05-3	Claim Frequency Code	Code specifying the frequency of the claim. This is the third position of the Uniform Billing Claim Form Bill Type.	7 8 Other Values	Replacement (Replacement of prior claim) Void (Void/Cancel of prior claim) Original Claim The Claim Frequency Code is the third character of the UB Type of Bill field on institutional encounters.
2300	CLM	CLM20	Delay Reason Code	Code indicating the reason why delayed	1 2 3 4 5 6 7 8 9 10 11	Proof of Eligibility Unknown or Unavailable Litigation Authorization Delays Delay in Certifying Provider Delay in Supplying Billing Forms Delay in Delivery of Custom-made Appliances Third Party Processing Delay Delay in Eligibility Determination Original Claim Rejected or Denied Due to a Reason Unrelated to the Billing Limitation Rules Administration Delay in the Prior Approval Process Other This data element can be entered when an encounter is submitted late (after the contracted of filing requirement). If the reason for the delay is not specified in the list, enter “11” (Other).
2300	CN1	CN101	Contract Type Code	Code identifying a contract type	01 02 03 04 05 06 09	Diagnosis Related Group (DRG) Per Diem Variable Per Diem Flat Capitated Percent Other Enter the value that best describes the facility’s relationship to the health plan.

837 INSTITUTIONAL ENCOUNTER TRANSACTION SPECIFICATIONSS						
Loop ID	**Segt ID**	**Element ID**	**Element Name**	**Element Definition**	**Valid Values**	**Definition/Format**
2300	REF	REF01	Reference Identification Qualifier	Code qualifying the reference identification	F8	Original Reference Number This REF Segment is required on replacement and void claims. The Original Reference Number is the AHCCCS CRN assigned to the encounter being replaced or voided (when CLM05-3 = “7” or “8”).
2300	REF	REF02	Claim Original Reference Number	Number assigned by a processor to identify a claim		The AHCCCS assigned Claim Reference Number (CRN) for the encounter being replaced or voided.
2320	SBR	SBR01	Payer Responsibility Sequence Number Code	Code identifying the insurance carrier's level of responsibility for a payment of a claim	P or S or T	Primary or Secondary or Tertiary The SBR Other Subscriber Information Loop can occur up to ten times for up to ten payers other than AHCCCS. One iteration of the loop is always for the individual health plan that submits the encounter. SBR Loops in addition to the health plan loop are for payers other than the member’s health plan. They can have any responsibility sequence and may be for subscribers other than the health plan member (e.g., family members). Note that the 2320 Loop is an “umbrella loop” that contains within it Loops 2330A through 2330E. All of these loops can be repeated as needed for each payer.

837 INSTITUTIONAL ENCOUNTER TRANSACTION SPECIFICATIONSS						
Loop ID	**Segt ID**	**Element ID**	**Element Name**	**Element Definition**	**Valid Values**	**Definition/Format**
2320	CAS	CAS02	Adjustment Reason Code	Code that indicates the reason for the adjustment	Many Code Set Values	Hundreds of Adjustment Reason Code values are maintained on the Washington Publishing Company's Web Site (www.wpc-edi.com). Enter the code value that best describes the reason for the difference between the Charged Amount and the Paid Amount. These are the same Adjustment Reason Codes that appear on the 835 Claim Remittance Advice Transaction. The 837 Transaction is designed to pick them up from the other payer's 835. If a health plan transmits 835 Remittance Advice Transactions to providers, data from these transactions can be the source of the Adjustment Reason Code(s) on the initial health plan iteration of the 2320 Loop. For subsequent other carriers, the Adjustment Reason Code(s) can be transferred (or generated by the health plan) if available.
2320	CAS	CAS03	Adjustment Amount	Adjustment amount for the associated reason code		The difference between the claim level Charged Amount and Paid Amount associated with the Adjustment Reason Code in CAS02.
2320	CAS	CAS04	Adjustment Quantity	Numeric quantity associated with the related reason code for coordination of benefits		The difference between the billed and paid units of service for all service lines when the difference is the result of claim level adjudication and is associated with the Adjustment Reason Code in CAS02.
2320	AMT	AMT01	Payer Prior Payment	Code qualifying the COB Payer Prior Payment	C4	Amount the payer has paid to the provider towards this claim.
2320	AMT	AMT02	Other Payer Patient Paid Amount	The amount this payer has paid to the provider towards this bill.		On health plan 2320 COB Loops, this element is for the Health Plan Paid Amount. For other carriers, it is the amount paid to the provider by that carrier.
2320	AMT	AMT01	COB Allowed Amount Qualifier	Code qualifying the COB Allowed Amount	B6	The encounter level Allowed Amount for the payer of this 2320 Loop.

837 INSTITUTIONAL ENCOUNTER TRANSACTION SPECIFICATIONSS						
Loop ID	**Segt ID**	**Element ID**	**Element Name**	**Element Definition**	**Valid Values**	**Definition/Format**
2320	AMT	AMT02	COB Allowed Amount	The maximum amount determined by the payer as being 'allowable' under the provisions of the contract prior to the determination of actual payment		The encounter level Allowed Amount for the payer of this 2320 Loop. For health plan 2320 Loops, the Allowed Amount is always greater than zero.
2320	DMG	DMG02	Other Insured Birth Date	The birth date of the additional insured individual		The "other subscriber's" birth date in CCYYMMDD format. This DMG Segment is not needed on health plan 2320 Loops. In additional other payer loops, this is the birth date of the subscriber (who may or may not be the same as the member).
2320	MIA	MIA01	Covered Days or Visits Count	The quantity of covered days or visits		Enter "000" in MIA01if no value is available for Covered Days or Visits. The Medicare Inpatient Adjudication MIA Segment is required if data for it is available from an electronic remittance advice (835 Transaction). This segment is used for inpatient adjudication Information, including standard HIPAA Remark Codes, generated by Medicare or another carrier. Institutional 837s have both MIA and MOA (Medicare Outpatient Adjudication) Segments. With the exception of Element MIA01, which is required, if the MIA Segment is present, data elements within the MIA Segment are situational. They reflect adjudication by Medicare or another payer and should be included if available to the health plan.

837 INSTITUTIONAL ENCOUNTER TRANSACTION SPECIFICATIONSS						
Loop ID	**Segt ID**	**Element ID**	**Element Name**	**Element Definition**	**Valid Values**	**Definition/Format**
2320	MOA	MOA01	Reimbursement Rate	Rate used when payment is based upon a percentage of applicable charges		The Medicare Outpatient Adjudication MOA Segment is required if data for it is available from an electronic remittance advice (835 Transaction). This segment is used for outpatient adjudication Information, including standard HIPAA Remark Codes generated by Medicare or another carrier. The MIA Segment carries similar data, including Remark Codes, for inpatient encounters. All data elements within both MIA and MOA Segments are situational. They will reflect adjudication by Medicare or another payer and should be included if available to the health plan. The MOA01 element carries the payer's Reimbursement Rate if payment is based on a percentage.
2330A	NM1	NM109	Other Insured Identifier	An identification number, assigned by the third party payer, to identify the additional insured individual		In the health plan 2320 Loop, the member's AHCCCS ID. In subsequent 2320 Loops, the Subscriber ID assigned by the other payer.
2330B	NM1	NM108	Identification Code Qualifier	Code designating the system/method of code structure used for Identification Code	PI	Payer identification
2330B	NM1	NM109	Other Payer Primary Identifier	An identification number for the other payer		In the health plan 2320 Loop, the health plan's AHCCCS ID, TSN, and Input Mode. In subsequent 2320 Loops, any identification number assigned to the other payer.
2330B	REF	REF01	Reference Identification Qualifier	Code qualifying the reference identification	F8	Original Reference Number Use code F8 to indicate the payer's claim number assigned to this claim by the health plan or other payer referenced in this iteration of Loop 2330B.
2330B	REF	REF02	Other Payer Secondary Identifier	Additional identifier for the other payer organization		The health plan's or other carrier's claim control number for the claim the resulted in this encounter. This is not the CRN that AHCCCS assigns to the encounter.

837 INSTITUTIONAL ENCOUNTER TRANSACTION SPECIFICATIONSS						
Loop ID	**Segt ID**	**Element ID**	**Element Name**	**Element Definition**	**Valid Values**	**Definition/Format**
2330B	REF	REF01	Reference Identification Qualifier	Code qualifying the reference identification	9F	Referral Number Enter only if a Referral or Prior Authorization Number is present.
2330B	REF	REF02	Other Payer Prior Authorization or Referral Number	The non-destination (COB) payer's prior authorization or referral number		The encounter level Referral or Prior Authorization Number used by the health plan or other carrier.
2400	SV2	SV202-1	Product or Service ID Qualifier	Code identifying the type/source of the descriptive number used in Product/Service ID		One or more HCPCS Procedure Code is required for all outpatient institutional encounters. A service line procedure can also be included on inpatient encounters if applicable.
2430	SVD	SVD01	Payer Identifier	Number identifying the payer organization		The 2430 Service Line Adjudication Information Loop is required if the claim that resulted in this encounter had been previously adjudicated by a payer identified in Other Payer Name Loop 2330B and this service line has adjustments (differences between charged and paid amounts) applied to it. There is no HIPAA standard for the payer identifier. For AHCCCS encounters, it must match a payer identifier in an Other Payer Name 2330B Loop. For health plan payers, SVD01, if present, should carry the same AHCCCS Health Plan ID and Transmission Submitter Number (TSN) as NM109 in Loop 2330B. For subsequent other payer Loops, use available Payer ID Numbers and names.
2430	SVD	SVD02	Service Line Paid Amount	Amount paid by the indicated payer for a service line		This is the Health Plan Paid Amount at the service line level.

837 INSTITUTIONAL ENCOUNTER TRANSACTION SPECIFICATIONSS						
Loop ID	**Segt ID**	**Element ID**	**Element Name**	**Element Definition**	**Valid Values**	**Definition/Format**
2430	CAS	CAS01	Claim Adjustment Group Code	Code identifying the general category of payment adjustment	CO CR OA PI PR	Contractual Obligations Correction and Reversals Other Adjustments Payer Initiated Reductions Patient Responsibility Enter the code value that best describes the reason for the different between the Charged Amount and the Paid Amount for this service line. This CAS Segment is used only when an adjustment or payment is at the service line level. The “Adjustment Trio” of Adjustment Reason, Amount, and Quantity can occur up to six times per CAS Segment and CAS Segments have up to 99 iterations per service line.
2430	CAS	CAS02	Adjustment Reason Code	Code that indicates the reason for the adjustment	Many Code Set Values	Hundreds of Adjustment Reason Code values are maintained on the Washington Publishing Company’s Web Site (www.wpc-edi.com). Enter the code value that best describes the reason for the difference between the Charged Amount and the Paid Amount.
2430	CAS	CAS03	Adjustment Amount	Adjustment amount for the associated reason code		The difference between the service line level Charged Amount and Paid Amount associated with the Adjustment Reason Code in CAS02.
2430	CAS	CAS04	Adjustment Quantity	Numeric quantity associated with the related reason code for coordination of benefits		The difference between the billed and paid units of service when the difference is the result of line level adjudication and is associated with the Adjustment Reason Code in CAS02.